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{D 000}	Initial Comments The Adult Care Licensure Section and the Dare County Department of Social Services conducted a follow-up survey on July 9, 2018 through July 13, 2018 with an exit conference via telephone on July 13, 2018.	{D 000}		
D 201	10A NCAC 13F .0604 (e)(1)(A)(B)(C) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)	D 201		

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D 201	Continued From page 1	D 201		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to assure aide hours met the minimum requirements on 10 of 48 shifts resulting in inadequate staff to meet the personal care and supervision needs of residents.

The findings are:

Interview with a resident on 07/09/18 at 3:00pm revealed:
-The facility was short of help especially the last few weeks.
-I don't need staff to help me, but other residents need help.
-I worry about the other residents not getting the help they need.
-I had my walker and I pushed another resident in her wheel chair so she could get down the hall because there is not enough staff.
-Management said they are looking for more help.

Interview with a second resident on 07/09/18 at 3:22 p.m. revealed:
-There were often not enough staff working at the facility.
-The facility was shorthanded all around.
-Personal care aides (PCAs) often had to help out in the kitchen and with other tasks.

Interview with a third resident on 07/09/18 at 3:40pm revealed, there was not enough help, when I ring my call light sometimes I have to wait

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D 201	Continued From page 2 a long time (shecould not remember exactly how long). Interview with a personal care aide (PCA) on 07/10/18 at 9:40am revealed: -She usually worked alone on the third shift in the assisted living section. -There were rarely two PCAs on the schedule for the third shift. -The lack of adequate staff was not safe for the residents. -There were falls all the time on the third shift. Interview with a PCA on 07/10/18 at 11:51 a.m. revealed: -She usually worked first shift. -Sometimes she worked twelve hour shifts because there were more issues with schedules on 2nd and 3rd shift. -There had been a lot of admissions at the facility but there were not enough staff to cover the schedule. -The Assistant Resident Care Director (ARCD) often covered holes in the schedule. Interview with a medication aide (MA) on 07/10/18 at 4:20pm revealed: -When staff called out, the policy was to call three people to cover that shift. -If there was no response the manager would stay to fill the spot. Interview with a different MA on 07/10/18 at 5:05 p.m. revealed: -They did not have enough help at the facility. -She worked all three shifts. -On third shift, there was one aide in assisted living, one aide in special care, and one MA for the entire building on most nights.	D 201		

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Interview with a PCA on 07/11/18 at 8:41 a.m. revealed:
-She usually worked all shifts at the facility and in both assisted living and special care.
-A lot of employees had left the facility in the last few months.
-On third shift, there was usually one PCA in assisted living, one PCA in the special care unit, and one medication aide (MA) for the entire building.
-The third shift schedule had been this way for about a month.
-The facility started scheduling staff for 12 hour shifts to help with the issue.
-There was a bigger problem with staffing on the weekends.
-The Interim Executive Director (ED) and the ARCD made the schedule for the building.
-There were several residents who were unsteady and often uncooperative.
-It was difficult for one PCA to assist all residents.
-There had been quite a few falls on the third shift.

Interview with a MA/Supervisor on 07/11/18 at 10:52 a.m. revealed:
-She sometimes worked third shift as a PCA.
-The last three times she worked as a PCA, she was the only PCA in the assisted living unit.
-There was one MA in the building.

Interview with a PCA on 07/13/18 at 3:15am revealed:
-There were 2 PCA's working the third shift.
-This was the first night in a long time that there were 2 PCA's working the third shift.
-There was usually only 1 PCA scheduled to work the third shift in the assisted living section at the facility.
-Two PCAs were needed on the third shift so staff

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could answer the call lights and help the residents when they called for assistance.

Review of third shift staff time records and the facility census for 06/24/18-06/30/18 revealed:
-There were 47 residents in the assisted living side of the facility on 06/25/18-06/26/18 which required 16 aide hours for third shift.
-There were 9 hours of aide hours for third shift on 06/25/18, leaving the facility short 7 hours of aide hours.
-There were 10 hours of aide hours for third shift on 06/26/18, leaving the facility short 6 hours of aide hours.
-There were 47 residents in the assisted living side of the facility on 06/29/18 which required 16 aide hours for third shift.
-There were 9 hours and 30 minutes of aide hours for third shift on 06/29/18, leaving the facility short 6 hours and 30 minutes of aide hours.

Review of the first shift staff time records and the facility census for 07/02/18 and 07/04/18 revealed:
-There were 51 residents in the assisted living side of the facility for 07/02/18 and 07/04/18 which required 24 hours of aide hours.
-There were 22.25 hours of aide time on 07/02/18, leaving the facility short 1.75 hours of aide hours.
-There were 22.75 hours of aide time on 07/04/18, leaving the facility short 1.75 hours of aide hours.

Review of the third shift staff time records and the facility census for the period of 07/01/18-07/09/18 revealed:
-There were 51 residents on the assisted living side of the facility from 07/01/18-07/09/8 which

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D 201	Continued From page 5 required 16 hours of aide hours. -There were 9.25 hours on 07/03/18 leaving the facility short 6.75 hours of aide hours. -There were 9.25 hours on 07/04/18 leaving the facility short 6.75 hours of aide hours. -There were 9.25 hours on 07/06/18 leaving the facility short 6.75 hours of aide hours. -There were 10.75 hours on 07/07/18 leaving the facility short 5.25 hours of aide hours. -There were 7.75 hours on 07/ 08/18 leaving the facility short 8.25 hours of aide hours. Interview with the Interim Executive Director on 07/12/18 at 11:30am revealed: -Some staff had left the facility for better paying jobs. -They were actively trying to recruit staff. -They had hired two new staff that did not show up to work. -The interim Executive Director was aware that the census was increasing due to daily admissions despite the facility being short staffed. -There currently was not a plan to address the short staffing issue in the building.	D 201		
{D 270}	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION	{D 270}		

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{D 270}	Continued From page 6 Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide the necessary supervision of 1 of 1 sampled residents (#8) who exhibited erratic and sexually inappropriate behaviors toward residents and staff in the Special Care Unit(SCU). The findings are: Review of Resident #8's current FL-2 dated 01/02/2012 revealed: -Diagnoses included Alzheimer's disease, unspecified, Insomnia, generalized muscle weakness, and iron deficiency. -The resident had inappropriate behaviors of exposing himself in public. Review of the Resident Register for Resident #8 revealed the resident was admitted to the facility on 11/02/2016. Review of the assessment and care plan for Resident #8 dated 11/07/17 revealed: -He was sometimes disoriented, forgetful, and required reminders. -He required limited assistance with bathing and dressing. -He was independent in ambulation, toileting, transferring, and eating. Confidential interview with a staff member revealed: -Resident #8 had exposed himself to a female resident in the SCU activity room about two months ago and Resident #8 said to the female resident "look at it and touch it."	{D 270}		

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-Resident #8 was aware of his actions and Resident #8 was redirected to his room by staff.
-The incident was reported to the interim Executive Director immediately after.
-Resident #8 constantly made sexually inappropriate comments to female residents about their bodies.
-One female resident reported Resident #8 asked her to take her shirt off.
-Resident #8 tried to lure other female residents in the SCU to go into his room.
-At least 2 female residents had been found in Resident #8's room seated on the bed with Resident #8 in front of them.
-Resident #8 had also attempted to kiss female residents on the cheek and made kissing gestures towards them.
-Resident #8 had touched female residents' breasts and buttocks in an inappropriate manner several times.
-One female resident reported that Resident #8 had gotten into the bed with her but the staff were unsure if this actually occurred and could not recall the date this allegation was made.
-Staff tried to keep the female residents in the SCU away from Resident #8.
-Staff had reported all of these incidents to the interim Executive Director when they occurred.
-The interim Executive Director had told the staff to watch Resident #8 but no frequency had been given to the staff.
-There had been no change in the supervison of Resident #8 by the staff when the inappropiate incidents were reported.
-There was no facility policy as to how often residents should be supervised.
-Resident #8 did not have any special instructions on how he should be supervised.

Review of Resident #8's Resident Notes dated

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{D 270}	Continued From page 8 03/11/18 revealed Resident #8 rammed his wheelchair into another resident's chair. Review of Resident #8s Resident Notes dated 04/09/18 revealed Resident #8 hit a female resident in the chest. Review of Resident #8's Resident Notes dated 04/18/18 revealed Resident #8 kept touching other residents. Review of Resident #8's Resident Notes dated 04/30/18 revealed staff had to get the resident out of another resident's room. Review of Resident #8's Resident Notes dated 06/26/18 revealed Resident #8 tried to urinate in the hallway while female residents were present. Review of Resident #8's Resident Notes dated 07/02/18 revealed Resident #8 was observed holding a female resident's shirt in his hand while the female resident was only wearing a sports bra. Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed: -Last week, Resident #8 was holding a female resident's shirt and jacket when the MA exited the med room. -Prior to the MA entering the med room, the female resident was wearing a shirt and jacket. -The female resident was standing beside Resident #8 wearing only a sports bra when the MA exited the med room. -Resident #8 reported to staff that he was trying to help the female resident. -The interim Executive Director was made aware of this incident.	{D 270}		

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Review of Resident #8's Resident Notes dated 07/09/18 revealed staff heard a loud scream from Resident #8's room and found him and a female resident in the room together.

Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed:
-She was on duty the other day when she heard a resident scream in Resident #8's room.
-A female resident was locked in the room with Resident #8 when staff responded.
-Staff had to unlock the door to enter.
-The residents were fully clothed.
-The female resident told staff Resident #8 was trying to fix something.

Resident #8's Resident Notes dated 07/10/18 revealed Resident #8 had demonstrated inappropriate behavior with another female resident by touching her rear end and making a kissing gesture.

Observation of Resident #8 on 07/11/18 at 10:05am revealed:
-Resident #8 wheeled himself into the activity room in the SCU.
-Resident #8 was alert and dressed appropriately.
-Resident #8 inquired about finding the current newspaper for him to read.
-When Resident #8 found out a current newspaper was not available, Resident #8 turned his wheelchair around facing toward the SCU main hallway.

Interview with a medication aide (MA)/ Supervisor on 07/11/18 at 10:52 a.m. revealed:
-Resident # 8 was often "fresh" with the female residents.
-He often touched other residents.
-The interim Executive Director was aware of the

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last two incidents on 07/02/18 and 07/09/18.
-Staff were told that Resident #8's medications were being changed to help with his behaviors.
-Staff were told to monitor residents and ensure no one enters another resident's room.
-If residents go into another resident's room, staff were told to guide them out.
-Staff typically "have eyes" on the residents most of the time and know where they are because most residents stayed in the common areas.
-Resident #8 spent most of the day in common areas.
-Staff did two hour checks on all residents at night and more frequent checks on residents who were fall risks every 30 minutes to an hour.
-Resident #8 was monitored every two hours.

Interview with a PCA on 07/11/18 at 1:10 p.m. revealed:
-She had not seen Resident #8 touch any other residents.
-She had not seen Resident #8 go into any other resident's rooms recently.
-She checked on residents about every 30-45 minutes but at least every hour.
-There had been no special instructions on how to monitor Resident #8 when he was aggressive or exhibited sexually inappropriate behaviors.

Review of the Physician's Order Form dated 06/11/18 revealed:
-The Resident Care Director (RCD) sent notification to the primary care provider (PCP) that Resident #8 was having increased sexual behaviors and more urinary incontinence.
-The PCP responded on 06/20/18 by requesting Resident #8 be scheduled for an appointment.

Interview with the interim Executive Director on 07/11/18 at 1:36 p.m. revealed:

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{D 270}	Continued From page 11 -Resident #8 had been inappropriate with other residents. -Resident #8 often urinated in inappropriate places but she did not believe the resident was purposefully exposing himself. -Resident #8 thought one of the female residents was his wife. -She was aware of an incident in the activity room where the resident exposed himself but was not told Resident #8 had asked a female resident to touch him. -This female resident had made an allegation that Resident #8 had tried to rape her on 03/17/18 around 1:30 p.m. -The interim Executive Director told the Cottage Program Director to take statements from all staff persons on duty and to do an assessment on the female resident. -She instructed staff to watch Resident #8 after that incident but did not specify a timed check. -She was told that a second female resident was found in the room with Resident #8 but did not believe this incident to be sexual. -She was aware Resident #8 had touched one of the female residents in the last month but she did not know the details of where he touched this resident. -She planned to implement 30 minute checks on Resident #8. -She had messaged Resident #8's PCP last month regarding his increase in sexually inappropriate behaviors. -The resident was seen in the office. -She was not aware of the resident having any behaviors since that time. Interview with Resident #8's family member on 07/12/18 at 2:00 p.m. revealed: -Resident #8 moved to the special care unit in January of 2018.	{D 270}		

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-She was told yesterday 07/11/18 that Resident #8 was being kicked out of the facility.
-She was told Resident #8 needed to be separated from a few of the female residents on the unit.
-One of the female residents thought she was Resident #8's wife.
-She thought Resident #8 had been "touching" other residents and had some sexual behaviors.
-She had seen Resident #8 frequently sitting with a particular female resident when she visited the unit.
-She accompanied Resident #8 to the PCP visit on 06/27/18.
-Resident #8 was put on a medication to suppress his sexual desires.
-She was told it would take a month for the medication to work.
-Resident #8 had lost his ability to rationalize due to his Alzheimer's diagnosis.
-She was not aware of Resident #8 having any sexually inappropriate behaviors in March of 2018.
-The female residents were at fault for the problems with Resident #8.
-She believed Resident #8 only started having sexually inappropriate behaviors about a month ago.

Telephone interview with staff at the PCP's office on 07/12/18 at 2:10 p.m. revealed:
-Resident #8 was seen in the office on 06/27/18 for inappropriate sexual behavior.
-The PCP prescribed medications to lower the resident's sexual drive.
-Resident #8 had been exhibiting sexually inappropriate behavior for a couple of weeks including groping others at the facility.
-There was no information in the office note that Resident #8 had been accused of sexually

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 270}	Continued From page 13 assaulting a female resident in March of 2018. -The facility had not notified the office of any sexually inappropriate behaviors since the office visit on 06/27/18. -The staff person was not sure how long it would take the medications prescribed on 06/27/18 to have effect on Resident #8. -There was no information in the office note as to how often Resident #8 should be monitiored. _____ The facility's failure to supervise Resident #8, who had a documented history of exposing himself in public, resulted in at least 2 female residents in the Special Care Unit suffering physical and verbal sexual harassment for at least 4 months. This failure to provide supervision of these residents resulted in a substantial risk of serious physical harm and neglect; and constitutes a Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/12/18 for this violation.	{D 270}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to notify the medical	D 273		

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	HAL028001	A. BUILDING: _____ B. WING _____	R 07/13/2018

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provider for 1 of 1 sampled residents (#4) with blood sugars over 250 for three days in accordance with physician orders.

The findings are:

Review of Resident #4's current FL-2 dated 06/25/18 revealed diagnoses included traumatic subdural hemorrhage, unspecified dementia, hypertension, and diabetes mellitus I with neuropathy.

Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/25/18.

Interview with Resident #4 and his family member on 07/09/18 at 4:39 p.m. revealed:
-Resident #4 had only been residing at the facility for about two weeks.
-Resident #4 was not feeling well and had been sleeping all day on 07/09/18.
-Resident #4 had been sick since Sunday 07/08/18.
-His blood glucose reading was around 500 on Saturday evening 07/07/18.
-Resident #4's morning blood sugar reading on Sunday 07/08/18 was 319 and had dropped to 112 that morning of 07/09/18.
-She was unable to understand a lot of what Resident #4 had been saying today 07/09/18.
-She had requested assistance from staff to assess Resident #4.
-She believed Resident #4's high blood glucose was due to him missing one of his diabetes medications yesterday 07/08/18.

Review of Resident #4's Physician Order Form dated 07/03/18 revealed:
-The Resident Care Director contacted the

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primary care provider (PCP) requesting a protocol for instances of high blood sugar and low blood sugar because there were no monitoring system in place.
-The PCP ordered Resident #4 have finger sticks done for unusual somnolence.
-Resident #4's diabetic medication should be held for blood glucose readings below 110.
-The facility was to contact the PCP for blood glucose readings greater than 250.

Review of Resident #4's Resident Notes dated 07/08/18 revealed:
-Resident #4 seemed really tired and exhausted.
-The medication aide (MA)/ Supervisor checked the resident's blood glucose and a reading of 519 resulted.
-The MA administered the scheduled diabetic medication.
-The MA then contacted the PCP's office but was unable to reach the on call service.
-The MA rechecked Resident #4's blood glucose and the reading was 495.
-Resident #4's family member was present that day and reported that Resident #4 had an appointment at the PCP's office on Tuesday.
-Resident #4's family would notify the PCP of Resident #4's elevated blood glucose.

Interview with the MA/Supervisor on 07/12/18 at 4:12 p.m. revealed:
-Resident #4 was really tired on 07/08/18.
-Resident #4 was usually perky and pleasant and was not acting normally.
-The MA checked Resident #4's blood sugar and it was 519.
-She believed Resident #4 missed his morning dose of Januvia (Januvia is a medicine used to help lower blood sugar) due to leaving for church.
-The MA rechecked Resident #4's blood sugar

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and it was 495.
-The MA contacted the Interim ED who instructed her to call the PCP.
-There was no on call number available for the PCP when she called the office.
-Resident #4's family member requested not to send Resident #4 to the emergency room due to him having an appointment with his PCP on Tuesday 07/10/18.
-Resident #4 should have been sent out but his family member declined.

Interview with a second MA/Supervisor on 07/10/18 at 2:52 p.m. revealed:
-Resident #4's family member had taken him to the doctor.
-Resident #4's blood sugar was 366 on the morning of 07/10/18.
-Resident #4 did not complain of feeling bad that morning.
-She did not call the doctor but sent a note with Resident #4 to the doctor.
-She was aware that the resident did not feel well on yesterday 07/09/18 and his blood sugar was 112.
-She was aware of the parameters to call the doctor if Resident #4's blood sugar was over 250.
-These instructions were listed on Resident #4's medication administration record (MAR).
-If a MA contacted the PCP, this would be documented in the Resident Notes.

Interview with the PCP on 07/10/18 at 4:23 p.m. revealed:
-He had previously managed Resident #4 at the skilled nursing facility prior to being admitted to the facility.
-Resident #4 was usually alert and able to answer questions.
-It was unlike Resident #4 to be tired or lethargic

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and that would be a sign of blood sugar issues.
-He had signed Resident #4's FL-2 to be admitted to the facility and provided the parameters for the insulin administration.
-He had not been notified of the blood sugar readings of 519 and 495 on Sunday 07/08/18.
-He would have instructed staff to administer 10 units of insulin an hour until the resident's blood sugar dropped below 200.
-If staff were unable to reach him, he would have expected them to send Resident #4 to the emergency room.
-Resident #4 ran the risk of diabetic ketoacidosis by not receiving treatment when his blood sugar was that high.
-The PCP was not notified that Resident #4 had missed a dose of his diabetic medication but believed that contributed to his high blood sugars.
-He had not been contacted by the facility since Resident #4 was admitted.

Interview with Interim ED and Assistant Resident Care Director (ARCD) on 07/10/10 at 3:55 p.m. revealed:
-The Interim ED did not remember being notified of Resident #4's specific blood glucose readings of 519 or 495 on 07/08/18.
-The MA/Supervisor had called the Interim ED and notified her that Resident #4's blood sugar was high.
-If a resident had a blood sugar of 500 or higher, she would expect the MA to send the resident out to to the hospital to stabilize the blood sugar if no physician was available.
-Resident #4's family member had reported to the ARCD on 07/09/18 that Resident #4 was feeling tired and so the ARCD checked his blood sugar and got a reading of 344.
-Resident # 4 had an appointment that day on 07/10/18 with a new PCP to get blood glucose

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D 273	Continued From page 18 monitoring orders clarified so the ARCD did not contact the PCP but sent a note to the new provider to obtain new parameters for Resident #4's blood glucose. -The Interim ED was not aware Resident #4 had an order on the MAR to call the PCP for blood sugars. -If MAs checked a resident's blood sugar and got a reading of 519, the Interim ED expected MAs to call her and 911. The facility's failure to contact Resident #4's primary care provider regarding of blood sugars above 250 (519, 495, 344, and 366) for three days, placed the resident at risk of diabetic coma. This failure was detrimental to the health and welfare of the resident and constitutes a Type B violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/10/18 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 27, 2018.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to implement orders for 1 of 5 sampled residents (#$)with orders for blood glucose monitoring twice daily.

The findings are:

Review of Resident #4's current FL-2 dated 06/25/18 revealed diagnoses included traumatic subdural hemorrhage, unspecified dementia, hypertension, and diabetes mellitus I with neuropathy.

Review of Resident #4's Resident Register revealed he was admitted to the facility on 6/25/18.

Review of Resident #4's Physician Consult Visit-Notes & Orders dated 07/10/18 revealed:
-Resident #4's Levemir (Levemir is an insulin used to control blood sugars) was increased to 12 units daily at bedtime.
-Resident #4 was to continue taking Januvia (Januvia is a medicine used to help lower blood sugar) daily.
-Resident #4's blood sugar should be checked every morning before breakfast and before bed.
-Acceptable blood sugar ranges were 120-250 for Resident #4.

Review of Resident #4's Medication Administration Record dated July 2018 revealed:
-There was no order for a fasting blood sugar check in the morning or blood sugar check before bed.
-The insulin dose had been increased to 12 units at bed.

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D 276	Continued From page 20 -There was an order for the diabetic medication every morning at 8:00 a.m. Interview with the Interim ED on 07/12/18 at 12:15 p.m. revealed: -She had checked the orders for Resident #4 on the MAR. -The order to check a fasting morning blood sugar and blood sugar before bed was in the pending folder of the Medication Administration Record. -Medication Aides had to check the folder to approve new orders in order for them to be added to the MAR. -She had approved those orders and they were now visible on the MAR. Interview with the Pharmacist on 07/12/18 at 1:21 p.m. revealed: -The pharmacy received new orders for Resident #4 on 7/11/18 at 10:32 a.m. -These orders included increasing Levemir to 12 units at bedtime, take Januvia daily, and to check blood sugar before breakfast and before bed. -The orders were received and entered into the computer. -The orders then transfered to the electronic MAR as pending. -The facility staff had to approve or reject the orders in order for them to show up on the MAR. -Pending orders showed up in a red tab at the bottom of the screen with the number of orders. Interview with the Nurse Practitioner on 07/12/18 at 3:59 p.m. revealed: -She had seen Resident #4 on 07/10/18 to establish care with the practice. -It was recommended that Resident #4's blood glucose stay in the range of 120-250 according to his age range.	D 276		

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D 276	Continued From page 21 -She ordered an increase in Resident #4's daily insulin from 10 units to 12 units at bed. -Resident #4's blood sugar should be checked in the morning prior to breakfast and before bed. -She was not aware that Resident #4's blood sugar had not been checked since the order was written. -She had been made aware of Resident #4's blood glucose readings from the weekend and the days prior to him being seen on 07/10/18. -She was not concerned by the readings due to the resident being on insulin. -She was more concerned about Resident #4 having low blood sugars due to him being a fall risk. -She expected the facility to notify her if Resident #4's blood sugar readings dropped below 120 more than once or if the resident was unresponsive.	D 276		
{D 298}	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to offer snacks three times a day to residents in assisted living side of the facility. The findings are:	{D 298}		

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{D 298}	Continued From page 22 Interview with a resident on 07/09/18 at 3:00pm revealed: -She was offered a snack one time a day but not in her room it was in the activity room. -Staff have no time to pass snacks. -She had her own snacks in her room. Interview with a second resident on 07/09/18 at 3:40pm revealed: -She stayed in her room most of the time due to back pain. -Staff offered her a snack usually one time a day in the evening. -If she asked for a snack the staff would bring her one. Interview with a third resident on 07/09/18 revealed, staff never offered him a snack. Interview with a fourth resident on 07/09/18 at 4:20pm revealed she only got a snack when she asked for one. Interview with a fifth resident on 07/09/18 at 3:22 p.m. revealed snacks were out all day for residents in the front room. Interview with a sixth resident on 07/09/18 at 3:56 p.m. revealed: -Snacks were served midday or in the afternoon. -There were always sandwiches in the refrigerator for residents. Interview with a seventh resident on 07/09/118 at 4:22 p.m. revealed: -She sometimes got snacks at the facility. -She was not sure what time snacks were served. Observation on 07/09/18 revealed, there was a table between the front door and the front desk	{D 298}		

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{D 298}	Continued From page 23 against the wall with a basket of apples and oranges and a pitcher of water with cut up lemons in it and a stack of disposable cups. Observation on 07/12/18 at 10:25am revealed the snack cart with snacks was in the dining room. Observation during the survey on 07/09/18, 07/10/18, 07/11/18 and 07/12/18 revealed there were no snacks offered to residents in assisted living. Interview with the kitchen manager on 07/10/18 at 9:20am revealed: -The kitchen staff put items on the snack cart and left it in the dining room. -The personal care aides (PCAs) were supposed to pass the snacks out to the residents at 10:30am and 2:30pm. -The snack cart never left the dining room. Interview with a medication aide (MA)/Supervisor on 07/11/18 at 10:52 a.m. revealed: -Snacks were served at 3:00 p.m. -If residents asked for a snack, the staff would get them something. Interview with a personal care aide (PCA) on 07/11/18 at 2:30 p.m. revealed: -She thought snacks had already been served. -Snacks were supposed to be served at 2:00 p.m. Interview with a second PCA on 07/11/18 at 2:45 p.m. revealed: -Snacks were usually served between 2:00 p.m. and 2:30 p.m. -She did not realize it was 2:45 p.m. and believed they were running behind on passing out snacks. Interview with a resident on 07/12/18 at 12:40	{D 298}		

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{D 298}	Continued From page 24 p.m. revealed: -PCA's didn't usually pass out snacks. -She got a snack yesterday afternoon 07/11/18 some time after 2:00 p.m. -She thought this was unusual as she typically did not get snacks. -Snacks were supposed to be served two times daily but she did not know the times becuase they were not usually served. Interview with a MA on 07/12/18 at 8:20 a.m. revealed: -Snacks were served at 10:00 a.m. and between 1:00 and 2:30 p.m. -PCA's passed out snacks down the hall. -The kitchen staff prepped the snack cart daily. -Residents in the front common area were able to get their own snack from the snack bar by the door. Interview with a second MA on 07/12/18 at 8:59 a.m. revealed: -Snacks were served between 6:30 p.m. to 7:00 p.m. -The kitchen staff put snacks on the cart and the PCAs passed them out down the hall Interview with the Activity Coordinator on 07/11/18 at 9:55 a.m. revealed: -She sometimes served snacks with activities. -She planned to serve a snack that day 07/11/18 with the 10:30 a.m. activity. -Residents were still supposed to get a snack passed out by the PCA's. -The snacks she served were always extra. Interview with a cook on 07/12/18 at 9:00 a.m. revealed: -Kitchen staff filled the cart with fruit, chips, fruit bars, and crackers.	{D 298}		

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{D 298}	Continued From page 25 -The cart was filled every morning. -Staff did not pass out snacks and the snack cart stayed in the dining room. -She had occasionally seen a PCA come get a snack off the cart for a resident. Interview with the kitchen superviosr on 07/12/18 at 9:15 a.m. revealed the snack cart had only left the dining room once in three months. Interview with the executive director (ED) on 07/12/18 at 9:05am revealed, the snack table by the front door and front desk was refilled at 10am and in the evening and as needed.	{D 298}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observation, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (#2) was protected after complaints of being afraid of a male resident in the Special Care Unit and being subjected to inappropriate touching. The findings are:	D 338		

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D 338	Continued From page 26 Review of Resident #2's current FL-2 dated 12/28/17 revealed: -Diagnoses included unspecified dementia, primary hypertension, long-term use of anti-coagulants, and the presence of a pacemaker. -Resident #2 was ambulatory and intermittently disoriented. -The recommended level of care was the Special Care Unit (SCU). Review of the Resident Register revealed Resident #2 was admitted to the facility on 01/11/18. Review of Resident #2's care plan dated 04/09/18 revealed: -Resident #2 was sometimes disoriented and oriented to person only. -Resident #2 was forgetful and sometimes needed reminders. -Resident #2 was ambulatory and liked to wander from room to room. Review of the nurses' notes for Resident #2 revealed: -On 03/19/18 during the 7:00am to 3:00pm shift, Resident #2 complained of a male resident saying nasty things to her and she (Resident #2) was afraid of the male resident. -On 04/02/18 during the 7:00am to 3:00pm shift, Resident #2 stated a male resident asked her to lay in the bed and she said she didn't want to take her shirt off; the supervisor was aware and the male resident would be watched. -On 07/02/18, Resident #2 was taking her clothes off in front of other residents during the 3:00pm to 11:00pm shift.	D 338		

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D 338	Continued From page 27 Observation of Resident #2 on 07/09/18 at 3:30pm revealed: -Resident #2 was led down the SCU hall from her room to the sit in the living room area of the SCU with other residents. -Resident #2 was alert and dressed appropriately. -Resident #2 sat with her hands in her lap and mumbled occasionally to herself. -Resident #2 did not interact with the residents seated around her. -Resident #2 did respond to staff when staff called the resident by name. Interview with Resident #2 on 7/11/18 at 1:10pm revealed: -She could not recall who the male resident was who said nasty things to her. -She could not recall who the male resident was who asked her to lay in the bed or take off her shirt. -She could not remember taking off her shirt in front of the other residents on 07/02/18. Interview with a supervisor on 07/11/18 at 9:45am: -She was the supervisor who wrote the nurses' note on 03/19/18 and 04/02/18. -Resident #2 had complained about a male resident in the SCU who had said sexually inappropriate things and touched Resident #2 inappropriately on her breasts and buttocks -Resident #2 complained she was afraid of a male resident and the supervisor reported Resident #2's complaint to the interim Executive Director in March or April 2018. -The interim Executive Director told the staff to try keep the male resident away from Resident #2, but no other instructions were given. -The male resident sometimes made-believe Resident #2 was his wife and tried to kiss	D 338		

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Resident #2 and touch Resident #2's breasts.
-Staff had to watch the male resident because he often tried to get Resident #2 to come to his room alone.

Telephone interview with a second supervisor on 07/12/18 at 11:03am revealed:
-A male resident seemed to target Resident #2 and tried to get Resident #2 to go his room or touch Resident #2 in a sexually inappropriate manner.
-Resident #2 "will do whatever you ask her to do and the male resident knew that."
-The male resident tried to get Resident #2 to believe that "she was his wife and come to his room."
-"We try to keep an eye on her in the SCU because of the male resident".
-She was the supervisor who worked the 3:00pm -11:00pm shift on 07/02/18.
-Resident #2 was wearing a shirt and jacket seated next to a male resident in the living area of the SCU when the supervisor went inside the medication room for a minute.
-When the supervisor came out the medication room, Resident #2 was standing beside the male resident wearing only a sports bra and her shirt and jean jacket were in the hands of the male resident.
-The male resident reported to staff that he was trying to help Resident #2.
-"It happened so fast, I don't know what happened exactly."
-The supervisor assisted Resident #2 in putting her clothes back on and kept Resident #2 away from the male resident.
-The Administrator was made aware of the incident.

Confidential interview with a staff member

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revealed:
-Resident #2 had been subjected to a male resident exposing himself to her and making sexual advances to Resident #2.
-"A male resident has blown kisses, tried to kiss, talked fresh, and tried to coerce Resident #2 to come to his room on several occasions".
-Resident #2 said "a male resident had asked her to come to his room and lay in his bed (unable to specify the date)".
-There were concerns about Resident #2's vulnerability to the male resident and staff had found Resident #2 in the male resident's room alone several times (dates not specified).
-"Whatever you tell her (Resident #2) to do, she will do it without question because of her dementia".
-Staff tried to monitor Resident #2's interactions with the male resident, but it was hard to keep Resident #2 away from the male resident when their room assignments were side by side.
-Several staff had voiced their concerns about the male resident's interactions with Resident #2 in the SCU several times to the interim ED since April 2018.

Telephone interview with a family member regarding Resident #2 on 07/12/18 at 1:58pm revealed:
-Resident #2 had made an allegation that she had been raped by the same male resident in March 2018 but the family member did not believe the allegation.
-"Residents in the SCU are going to say and do things like that; that why they are in the SCU anyway".
-"The facility had investigated Resident #2's rape allegation and the family member did not believe any sexual assault had occurred".
-"As long as the staff are able to keep Resident

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#2 safe, I don't have a problem with her care.

Interview with a nurse with the physician's office for Resident #2 on 07/12/18 at 11:25am revealed:
-The physician was not aware of any reports from the facility about the Resident #2 being afraid of a male resident in the SCU.
-A family member of Resident #2 mentioned the rape allegation to the nurse with the physician's office in March 2018.
-Resident #2's family member did not believe anything had happened to Resident #2 and Resident #2 was never assessed by the physician.
-The nurse was unable to locate any notification or documentation from the facility regarding Resident #2's rape allegation or complaints of sexually inappropriate behaviors from a male resident.

Interview with the Interim Executive Director on 07/11/18 at 1:36pm revealed:
-She was aware of Resident #2's complaint of being afraid of a male resident in March 2018.
-Resident #2 reported to the SCU staff that a male resident had tried to rape her on 03/17/18.
-She had the SCU staff to provide written statements regarding Resident #2's allegation of being raped by a male resident.
-She instructed the SCU cottage program director to do a head-to-toe assessment on Resident #2 and there was no evidence of any type of assault was found on Resident #2.
-She spoke with a member of Resident #2's family regarding the Resident #2's rape allegation and she "instructed the staff to keep an eye" on Resident #2 and the male resident.
-Resident #2 was not further assessed by her physician and local law enforcement was not notified regarding Resident #2's allegations of

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D 338	Continued From page 31 rape because we did not see any evidence an assault had occurred and Resident #2's family was satisfied with the outcome of our internal investigation. -She did not know of any other staff reports or concerns regarding Resident #2 complaining of inappropriate sexual behavior from the male resident. -She had not thought about the vulnerability of Resident #2 and her room assignment continuing to be next to the male resident's room. -No staff had reported to her about Resident #2 disrobing in front of the male resident on 07/02/18 and she would have to further investigate the incident. -Her goal was to maintain the safety and dignity" of Resident #2 and all the residents in the SCU. The facility's failure to protect a Resident #2 who verbalized fear of a male resident after being subjected to inappropriate touching and verbal sexual comments from the same male resident including allegation of rape, resulted in substantial risk of serious abuse and neglect. This noncompliance constitutes a Type A2 Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 07/12/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 12, 2018.	D 338		
D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications	D 375		

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D 375	Continued From page 32 (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to assure compliance with the facility's policies and procedures for self-administration of medications for 1 of 1 sampled residents (#3). The findings are: Observation of Resident #3's room during the initial tour on 07/09/18 at 4:20pm revealed: -There was a Ventolin inhaler on her table next to the chair where she was sitting. -There were 3 Duo-neb single use medication doses lying on her table next to her chair. -There was a bottle of Zyrtec 10mg tablets in an open drawer next to her chair. -There was a bottle of Gentle Iron 25mg tablets. Review of resident #3's current FL2 dated 03/18/18 revealed: -Diagnoses included hypertension, diabetes, chronic obstructive pulmonary disease, atrial fibrillation, sleep apnea, rheumatoid arthritis, anemia, history of cellulitis.	D 375		

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D 375	Continued From page 33 -There was an order for Albuterol inhaler inhale 1 puff every 4 hours as needed may leave at bedside (generic for venolin used to treat chronic obstructive pulmonary disease). -There was an order for Enbrel 25mg/0.5ml sub cutaneous syringe twice a week may self-administer with reminders (used to treat rheumatoid arthritis). -There was an order for Duo-neb .5mg-3mg inhale via nebulizer 4 times a day (used to relax the muscles in the airway and increase air flow to the lungs). -There was no order to self-administer the Duo-neb via nebulizer. -There was an order for Zyrtec 10 mg daily as needed. -There was no order to self-administer the Zyrtec. -There was no order for Gentle Iron 25 mg Review of Resident #3's Resident Register revealed the Resident was admitted to the facility on 03/16/18. Review of Resident #3's Care Plan dated 04/11/18 revealed: -Resident #3 was oriented and had adequate memory. -There was no documentation Resident #3 self-administered any medications. Review of the facility's Self-Administration review book revealed there was no Self-Administration Medication reviews completed by the nurse for Resident #3 for the Enbrel injection or the Albuterol inhaler. Review of Resident #3's care notes revealed no documentation that Resident #3 had a self-administration assessment completed before self-administering Enbrel injection and Albuterol	D 375		

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D 375	Continued From page 34 inhaler. Interview with Resident #3 on 07/09/18 at 4:20pm revealed: -She self-administered her Enbrel injection when the staff brought it to her. -She took the Enbrel injection twice a week, she was not sure what days she took it. -She had been giving herself the Enbrel injection for a long time. -She used the Albuterol inhaler maybe 1 time a day when she was short of breath. -She did not remember the last time she used the Albuterol inhaler, but it was not recent. -She took the Zyrtec for allergies, she took it a few days ago but she was not sure what day. -She took the Gentle Iron tablets when she remembered. Interview with Resident #3 on 07/10/18 at 8:45am revealed: -The Duo-neb medication on her table was brought from home. -She did not want to give them up in case she needs it. -She did not remember using any of the Duo-nebs she brought from home. -The staff bring her the Duo-neb treatments 4 times a day. -The staff watch her do the treatment. -She did not remember being evaluated by the nurse for self-administration of the Enbrel injection or the Albuterol inhaler. -She was not sure if the medication aides (MA) knew she had the extra Duo-nebs or the Zyrtec in her room. Interview with a medication aide (MA) on 07/11/18 at 9:20am revealed: -She remembers seeing 3 or 4 doses of Duo-neb	D 375		

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next to Resident #3's nebulizer machine.
-Resident #3 does not have an order to self-administer the Duo-neb.
-Resident #3 brought the Duo-nebs on her table from home.
-Resident #3 did not want to give up the medication.
-She never observed Resident #3 using any of the Duo-nebs on her table.
-When she gave Resident #3 her Duo-neb treatments she never left it in the room, she watched her take it.
-She was not aware that Resident #3 had a bottle of Zyrtec in her room.
-Resident #3 does not have an order to self-administer her Zyrtec.
-She did not know Resident #3 had a bottle of Gentle Iron tablets in her room.

Interview with a MA on 07/12/18 at 8:20am revealed:
-She did not remember seeing any Duo-nebs in Resident #3's room.
-She knew Resident #3 did not have an order to self-administer her Duo-neb treatment.
-Resident #3 refuses her nebulizer treatment sometimes but she will leave it there for her to take when she is ready.
-She did not know Resident #3 had a bottle of Zyrtec in her room.
-Resident #3 did not have an order to self-administer the Zyrtec.
-Resident #3 did not ask for the as needed Zyrtec very often.
-Resident #3 did not have an order to self administer Iron tablets.

Interview with the Interim Executive Director (Interim ED) on 07/11/18 at 9:25am and 4:55pm revealed:

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D 375	Continued From page 36 -She knew about Resident #3 having an order to self-administer her Albuterol inhaler and Enbrel injection. -She was not aware Resident #3 had a bottle of Zyrtec, Gentle Iron and 3 Duo-nebs in her room. -She did not have any process for checking on residents to see if they have any new medications in their rooms. -She had done a quarterly review and check off for residents who self-administer medications and she would do a review as needed if staff noticed a decline in a resident. -She had not completed a self-administration review check off for Resident #3 for the Albuterol or the Enbrel injection. -She was responsible for completing the self-administration reviews and check off. -She was not sure why she had not completed the self-administration review check list for Resident #3 to self-administer medications. -She was going to complete a Self-administration Medication review for Resident #3 as soon as soon as possible. Review of the facility's policies and procedures for self-administration for medications revealed: -The resident must have an order from their physician that "Resident may self-administer medications". -The order must be updated quarterly. -The physician must write an order for every medication the resident is taking, prescription and over the counter. -At least quarterly, the Resident Care Director or designee must check the resident's medications for signs that medications may not be taken properly. -It should be documented in the resident care notes what was found each time there was a check for appropriate self-administration.	D 375		

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D 375	Continued From page 37 -A self-administration medication review would be completed with any new order to self-administer medications and at a minimum, every quarter thereafter and with any changes in condition.	D 375		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 7 of 48 shifts sampled from 06/24/18 through 07/09/18. The findings are: Interview with the supervisor on 07/11/18 at 9:25am revealed: -First shift staff hours were from 7:00am to 3:00pm. -Second shift staff hours were from 3:00pm to 11:00pm. -Third shift staff hours were from 11:00pm to 7:00am.	D 465		

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Review of the daily census report dated 06/24/18 revealed:
-The census for the special care unit (SCU) was 20 residents.
-20 hours of staff time was required for first and second shift.
-16 hours of staff time was required for third shift.

Review of the daily census report dated 06/25/18 revealed:
-The census for the SCU was 20 residents.
-20 hours of staff time was required for first and second shift.
-16 hours of staff time was required for third shift.

Review of the staff schedule and the timecard reports revealed for 06/25/18.
-There were 10 staff hours provided on third shift but 16 hours were required.
-This resulted in a shortage of 6 staff hours for a census of 20 SCU residents.

Review of the daily census report dated 06/26/18 revealed:
-The census for the SCU was 20 residents.
-20 hours of staff time was required for first and second shift.
-16 hours of staff time was required for third shift.

Review of the staff schedule and the timecard reports revealed for 06/26/18:
-There were 11.5 staff hours provided on third shift but 16 hours were required.
-This resulted in a shortage of 5.5 staff hours for a census of 20 SCU residents.

Review of the daily census report dated 06/27/18 revealed:
-The census for the SCU was 20 residents.
-20 hours of staff time was required for first and

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D 465	Continued From page 39	D 465		

second shift.
-16 hours of staff time was required for third shift.

Review of the daily census report dated 06/28/18 revealed:
-The census for the SCU was 20 residents.
-20 hours of staff time was required for first and second shift.
-16 hours of staff time was required for third shift.

Review of the daily census report dated 06/29/18 revealed:
-The census for the SCU was 20 residents.
-20 hours of staff time was required for first and second shift.
-16 hours of staff time was required for third shift.

Review of the daily census report dated 06/30/18 revealed:
-The census for the SCU was 19 residents.
-19 hours of staff time was required for first and second shift.
-15.2 hours of staff time was required for third shift.

Review of the staff schedule and the timecard reports revealed for 06/30/18:
-There were 10 staff hours provided on third shift but 15.2 hours were required on 06/30/18.
-This resulted in a shortage of 5.2 staff hours for a census of 19 SCU residents.

Review of the daily census report dated 07/01/18 revealed:
-The census for the SCU was 19 residents.
-19 hours of staff time was required for first and second shift.
-15.2 hours of staff time was required for third shift.

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	HAL028001	A. BUILDING: _____ B. WING _____	R 07/13/2018

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D 465	Continued From page 40 Review of the staff schedule and the timecard reports revealed for 07/01/18: -There were 10.5 staff hours provided on third shift but 15.2 hours were required on 07/01/18. -This resulted in a shortage of 4.7 staff hours for a census of 19 SCU residents. Review of the daily census report dated 07/02/18 revealed: -The census for the SCU was 19 residents. -19 hours of staff time was required for first and second shift. -15.2 hours of staff time was required for third shift. Review of the daily census report dated 07/03/18 revealed: -The census for the SCU was 20 residents. -20 hours of staff time was required for first and second shift. -16 hours of staff time was required for third shift. Review of the daily census report dated 07/04/18 revealed: -The census for the SCU was 20 residents. -20 hours of staff time was required for first and second shift. -16 hours of staff time was required for third shift. Review of the staff schedule and the timecard reports revealed for 07/04/18: -There were 15.75 staff hours provided on first shift but 20 hours were required. -This resulted in a shortage of 4.25 staff hours for a census of 20 SCU residents. Review of the daily census report dated 07/05/18 revealed: -The census for the SCU was 20 residents. -20 hours of staff time was required for first and	D 465		

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D 465	Continued From page 41	D 465		

second shift.
-16 hours of staff time was required for third shift.

Review of the daily census report dated 07/06/18 revealed:
-The census for the SCU was 21 residents.
-21 hours of staff time was required for first and second shift.
-16.8 hours of staff time was required for third shift.

Review of the daily census report dated 07/07/18 revealed:
-The census for the SCU was 21 residents.
-21 hours of staff time was required for first and second shift.
-16.8 hours of staff time was required for third shift.

Review of the staff schedule and the timecard reports revealed for 07/07/18:
-There were 11.5 staff hours provided on third shift but 16.8 hours were required.
-This resulted in a shortage of 5.3 staff hours for a census of 21 SCU residents.

Review of the daily census report dated 07/08/18 revealed:
-The census for the SCU was 21 residents.
-21 hours of staff time was required for first and second shift.
-16.8 hours of staff time was required for third shift.

Review of the daily census report dated 07/09/18 revealed:
-The census for the SCU was 22 residents.
-22 hours of staff time was required for first and second shift.

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D 465	Continued From page 42 -17.8 hours of staff time was required for third shift Review of the staff schedule and the timecard reports revealed for 07/09/18: -There were 16 staff hours provided on third shift but 17.6 hours were required on 07/09/18. -This resulted in a shortage of 1.6 staff hours for a census of 22 SCU residents. Review of the daily staff schedules for the SCU dated 06/24/18 - 07/08/18 revealed: -The names of the personal care aides were typed in blocks in the top of the schedule. -The names of the supervisors were written in blocks in the bottom of the schedule. -There were no differential for the schedule to identify first, second, or third shifts. -Employees' scheduled times were handwritten in the schedule adjacent to the block next to their names. Interview with the interim Executive Director on 07/11/18 at 1:36pm revealed: -There was no Special Care Coordinator (SCC) currently for the SCU. -There had been a problem with short staffing for the entire facility, not just the SCU, since the end of the spring. -She was responsible for managing the facility staffing schedule including staffing for the SCU. -She made out the schedule according to the resident census. -If there was a call-out, she would check with other staff to see if they could work in that slot. -If she could not find another staff to work in the vacant slot, she would work in place of other staff in order to cover resident care. -"I know we are sometimes working short-staffed in the SCU, but I don't know what else to do".	D 465		

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D 465	Continued From page 43 -"The facility was in the process of trying to recruit more staff, but it was hard being financially competitive with other organizations in this area this time of the year". -She was in the process of interviewing 2 new staff for the facility. Interview with the Regional Director on 07/12/18 at 11:25am revealed: -The facility was in the process of trying to recruit new staff through the local colleges and they had a recent job fair. -"It was hard trying to find qualified staff this time of year and be competitive with other organization". -He would continue to work with the interim Executive Director to hire more staff to ensure the needs of the residents, including the SCU were met at the facility.	D 465		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision and	{D912}		

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{D912}	Continued From page 44 health care. The findings are: Based on observations, interviews, and record reviews the facility failed to notify the medical provider for 1 of 1 sampled residents (#4) with blood sugars over 250 for three days in accordance with physician orders. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	{D912}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to assure residents were free of neglect as related to residents rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide the necessary supervision of 1 of 1 sampled residents (#8) who exhibited erratic and sexually inappropriate behaviors toward residents and staff in the Special Care Unit(SCU). [Refer to Tag D270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Unabated Type A2 Violation)]. 2. Based on observation, interviews, and record reviews, the facility failed to assure 1 of 1 sampled resident (#2) was protected after	D914		

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D914	Continued From page 45 complaints of being afraid of a male resident in the Special Care Unit and being subjected to inappropriate touching. [Refer to Tag D338, 10A NCAC 13F .0909 Residents Rights (Type A2 Violation)].	D914		